Filing at a Glance

Company:	Bankers Fidelity Life Insurance Company
Product Name:	Group Hospital Indemnity
State:	Arkansas
TOI:	H14G Group Health - Hospital Indemnity
Sub-TOI:	H14G.000 Health - Hospital Indemnity
Filing Type:	Form
Date Submitted:	09/10/2012
SERFF Tr Num:	BFLI-128600035
SERFF Status:	Closed-Approved-Closed
State Tr Num:	
State Status:	Approved-Closed
Co Tr Num:	AR B 20620 MP-E
Implementation Date Requested:	On Approval
Author(s):	Jill Jones, Bridgett Williams, Tina Cunningham, Lyn Ezell, Sharon White, Norma Christopher
Reviewer(s):	Rosalind Minor (primary)
Disposition Date:	10/15/2012
Disposition Status:	Approved-Closed
Implementation Date:	

State Filing Description:

State: Arkansas **Filing Company:** Bankers Fidelity Life Insurance Company
TOI/Sub-TOI: H14G Group Health - Hospital Indemnity/H14G.000 Health - Hospital Indemnity
Product Name: Group Hospital Indemnity
Project Name/Number: /

General Information

Project Name:
Project Number:
Requested Filing Mode: Review & Approval
Explanation for Combination/Other:
Submission Type: New Submission
Group Market Type: Employer
Filing Status Changed: 10/15/2012
State Status Changed: 10/15/2012
Created By: Tina Cunningham
Corresponding Filing Tracking Number:

Status of Filing in Domicile: Authorized
Date Approved in Domicile: 06/28/2012
Domicile Status Comments:
Market Type: Group
Group Market Size: Small and Large
Overall Rate Impact:

Deemer Date:
Submitted By: Tina Cunningham

Filing Description:

The enclosed forms are being submitted to your department for formal review and approval. The product will be issued to employer and labor union groups. The policy and certificate forms are computer-generated, laser-printed and presented in final print with “John Doe” information. An actuarial memorandum with rates, demonstrating cost and benefit structure is enclosed. These forms are new and will not replace any previously approved forms.

The product provides hospital indemnity benefits for covered accidents and sickness. Optional benefits are available for surgery, doctor's office visits, wellness screenings and emergency accident coverage.

Company and Contact

Filing Contact Information

Tina Cunningham, Compliance Analyst L1
4370 Peachtree Road NE
Atlanta, GA 30319

tcunningham@atlam.com
404-266-5723 [Phone]
404-926-4092 [FAX]

Filing Company Information

Bankers Fidelity Life Insurance Company
4370 Peachtree Rd NE
Atlanta, GA 30319
(404) 266-5600 ext. [Phone]

CoCode: 61239
Group Code: 587
Group Name: 61239
FEIN Number: 58-0658963

State of Domicile: Georgia
Company Type: Life & Health
State ID Number:

Filing Fees

Fee Required?	Yes
Fee Amount:	$175.00
Retaliatory?	Yes
Fee Explanation:	$50.00 per form X 2 $75.00 per rate
Per Company:	No

SERFF Tracking #: *BFLI-128600035* ***State Tracking #:*** ***Company Tracking #:*** *AR B 20620 MP-E*

State: *Arkansas* ***Filing Company:*** *Bankers Fidelity Life Insurance Company*
TOI/Sub-TOI: *H14G Group Health - Hospital Indemnity/H14G.000 Health - Hospital Indemnity*
Product Name: *Group Hospital Indemnity*
Project Name/Number: */*

Company	Amount	Date Processed	Transaction #
Bankers Fidelity Life Insurance Company	$175.00	09/10/2012	62527647
Bankers Fidelity Life Insurance Company	$325.00	09/13/2012	62658391

SERFF Tracking #:	*BFLI-128600035*	***State Tracking #:***		***Company Tracking #:***	*AR B 20620 MP-E*

State:	*Arkansas*	***Filing Company:***	*Bankers Fidelity Life Insurance Company*
TOI/Sub-TOI:	*H14G Group Health - Hospital Indemnity/H14G.000 Health - Hospital Indemnity*		
Product Name:	*Group Hospital Indemnity*		
Project Name/Number:	*/*		

Correspondence Summary

Dispositions

Status	Created By	Created On	Date Submitted
Approved-Closed	Rosalind Minor	10/15/2012	10/15/2012

Objection Letters and Response Letters

Objection Letters

Status	Created By	Created On	Date Submitted
Pending Industry Response	Rosalind Minor	09/14/2012	09/14/2012
Pending Industry Response	Rosalind Minor	09/10/2012	09/10/2012

Response Letters

Responded By	Created On	Date Submitted
Tina Cunningham	10/15/2012	10/15/2012
Tina Cunningham	09/13/2012	09/13/2012

Amendments

Schedule	Schedule Item Name	Created By	Created On	Date Submitted
Supporting Document	Actuarial Memorandum	Tina Cunningham	09/10/2012	09/10/2012

Filing Notes

Subject	Note Type	Created By	Created On	Date Submitted
Arbitration Provision	Note To Reviewer	Tina Cunningham	10/15/2012	10/15/2012
Objection Letter of 9/14/12	Note To Filer	Rosalind Minor	10/15/2012	10/15/2012

SERFF Tracking #:	*BFLI-128600035*	***State Tracking #:***		***Company Tracking #:***	*AR B 20620 MP-E*

State:	*Arkansas*	***Filing Company:***	*Bankers Fidelity Life Insurance Company*
TOI/Sub-TOI:	*H14G Group Health - Hospital Indemnity/H14G.000 Health - Hospital Indemnity*		
Product Name:	*Group Hospital Indemnity*		
Project Name/Number:	*/*		

Disposition

Disposition Date: 10/15/2012
Implementation Date:
Status: Approved-Closed
Comment:

Company Name:	Overall % Indicated Change:	Overall % Rate Impact:	Written Premium Change for this Program:	# of Policy Holders Affected for this Program:	Written Premium for this Program:	Maximum % Change (where req'd):	Minimum % Change (where req'd):
Bankers Fidelity Life Insurance Company	0.000%	0.000%	$0	0	$0	0.000%	0.000%

SERFF Tracking #:	*BFLI-128600035*	***State Tracking #:***		***Company Tracking #:***	*AR B 20620 MP-E*

State:	*Arkansas*	***Filing Company:***	*Bankers Fidelity Life Insurance Company*
TOI/Sub-TOI:	*H14G Group Health - Hospital Indemnity/H14G.000 Health - Hospital Indemnity*		
Product Name:	*Group Hospital Indemnity*		
Project Name/Number:	*/*		

Schedule	Schedule Item	Schedule Item Status	Public Access
Supporting Document	Flesch Certification	Approved-Closed	Yes
Supporting Document	Application	Approved-Closed	Yes
Supporting Document	Statement of Variability	Approved-Closed	Yes
Supporting Document	Actuarial Memorandum	Approved-Closed	No
Form (revised)	Group Policy - Hospital Confinement Indemnity	Approved-Closed	Yes
Form	Group Policy - Hospital Confinement Indemnity	Replaced	Yes
Form	Certificate of Insurance - Hospital Confinement Indemnity	Approved-Closed	Yes
Form	Optional Benefit - Daily Hospital Confinement	Approved-Closed	Yes
Form	Optional Benefit - First Day Hospital Confinement	Approved-Closed	Yes
Form	Optional Benefit - Emergency Accident	Approved-Closed	Yes
Form	Optional Benefit - Physician's Office Visit	Approved-Closed	Yes
Form	Optional Benefit - Surgical Indemnity	Approved-Closed	Yes
Form	Optional Benefit - Health Screening	Approved-Closed	Yes
Form	Employer Agreement	Approved-Closed	Yes
Form	Enrollment Form	Approved-Closed	Yes

State: Arkansas **Filing Company:** Bankers Fidelity Life Insurance Company
TOI/Sub-TOI: H14G Group Health - Hospital Indemnity/H14G.000 Health - Hospital Indemnity
Product Name: Group Hospital Indemnity
Project Name/Number: /

Objection Letter

Objection Letter Status	Pending Industry Response
Objection Letter Date	09/14/2012
Submitted Date	09/14/2012
Respond By Date	

Dear Tina Cunningham,

Introduction:

This will acknowledge receipt of the captioned filing.

Objection 1

- Group Policy - Hospital Confinement Indemnity, B 20620 MP-E (Form)

Comments: Please acknowledge that Arkansas certificateholders will not be involved in Binding Arbitration. Please refer to ACA 23-79-203.

Conclusion:

A.C.A. 23-79-109(1)-(5) sets forth the procedure by which filings may be deemed approved upon the expiration of certain time periods with no affirmative action by the commissioner. If the commissioner determines that additional information is needed to make a decision regarding approval, such request for information will be made to the company. The filing will not be considered complete until said additional information is received. The time periods set forth in this statute will not begin to run until the filing is complete.

Please feel free to contact me if you have questions.

Sincerely,

Rosalind Minor

SERFF Tracking #:	*BFLI-128600035*	***State Tracking #:***		***Company Tracking #:***	*AR B 20620 MP-E*

State:	*Arkansas*	***Filing Company:***	*Bankers Fidelity Life Insurance Company*
TOI/Sub-TOI:	*H14G Group Health - Hospital Indemnity/H14G.000 Health - Hospital Indemnity*		
Product Name:	*Group Hospital Indemnity*		
Project Name/Number:	*/*		

Response Letter

Response Letter Status	Submitted to State
Response Letter Date	10/15/2012
Submitted Date	10/15/2012

Dear Rosalind Minor,

Introduction:

Thank you for your time in review of this filiing.

Response 1

Comments:

The Arbitration Provision has been removed.

Related Objection 1

Applies To:

- Group Policy - Hospital Confinement Indemnity, B 20620 MP-E (Form)

Comments: Please acknowledge that Arkansas certificateholders will not be involved in Binding Arbitration. Please refer to ACA 23-79-203.

Changed Items:

No Supporting Documents changed.

SERFF Tracking #:	*BFLI-128600035*	***State Tracking #:***		***Company Tracking #:***	*AR B 20620 MP-E*

State:	*Arkansas*	***Filing Company:***	*Bankers Fidelity Life Insurance Company*
TOI/Sub-TOI:	*H14G Group Health - Hospital Indemnity/H14G.000 Health - Hospital Indemnity*		
Product Name:	*Group Hospital Indemnity*		
Project Name/Number:	*/*		

Form Schedule Item Changes

Item No.	Form Number	Form Type	Form Name	Action/ Action Specific Data	Readability Score	Attachments	Submitted
1	B 20620 MP-E	POL	Group Policy - Hospital Confinement Indemnity	Initial	46.300	B 20620 MP-E AR.pdf	Date Submitted: 10/15/2012 By: Tina Cunningham
Previous Version							
1	*B 20620 MP-E*	*POL*	*Group Policy - Hospital / Confinement Indemnity*	*Initial*	*46.300*	*B 20620 MP-E.pdf*	*Date Submitted: 10/15/2012 By: Tina Cunningham*

No Rate/Rule Schedule items changed.

Conclusion:

Sincerely,
Tina Cunningham

State: Arkansas **Filing Company:** Bankers Fidelity Life Insurance Company
TOI/Sub-TOI: H14G Group Health - Hospital Indemnity/H14G.000 Health - Hospital Indemnity
Product Name: Group Hospital Indemnity
Project Name/Number: /

Objection Letter

Objection Letter Status	Pending Industry Response
Objection Letter Date	09/10/2012
Submitted Date	09/10/2012
Respond By Date	10/10/2012

Dear Tina Cunningham,

Introduction:

This will acknowledge receipt of the captioned filing.

Objection 1

- Group Policy - Hospital Confinement Indemnity, B 20620 MP-E (Form)
- Certificate of Insurance - Hospital Confinement Indemnity, B 20620 CRT-E (Form)
- Optional Benefit - Daily Hospital Confinement, B 20620 CRT-E OPB1 (Form)
- Optional Benefit - First Day Hospital Confinement, B 20620 CRT-E OPB2 (Form)
- Optional Benefit - Emergency Accident, B 20620 CRT-E OPB8 (Form)
- Optional Benefit - Physician's Office Visit, B 20620 CRT-E OPB9 (Form)
- Optional Benefit - Surgical Indemnity, B 20620 CRT-E OPB10 (Form)
- Optional Benefit - Health Screening, B 20620 CRT-E OPB11 (Form)
- Employer Agreement, B 0214 CA (Form)
- Enrollment Form, B 0214 EDF2012 (Form)

Comments:

Our filing fees under Rule and Regulation 57 have been updated. Please review the General Instructions for ArkansasLH or Rule and Regulation 57.

The fee for this submission is $50.00 per form for a total of $500.00. Please submit an additional $325.00 for this submission.

We will begin our review of this submission upon receipt of the additional filing fee.

Conclusion:

A.C.A. 23-79-109(1)-(5) sets forth the procedure by which filings may be deemed approved upon the expiration of certain time periods with no affirmative action by the commissioner. If the commissioner determines that additional information is needed to make a decision regarding approval, such request for information will be made to the company. The filing will not be considered complete until said additional information is received. The time periods set forth in this statute will not begin to run until the filing is complete.

Please feel free to contact me if you have questions.

Sincerely,
Rosalind Minor

State: Arkansas **Filing Company:** Bankers Fidelity Life Insurance Company
TOI/Sub-TOI: H14G Group Health - Hospital Indemnity/H14G.000 Health - Hospital Indemnity
Product Name: Group Hospital Indemnity
Project Name/Number: /

Response Letter

Response Letter Status	Submitted to State
Response Letter Date	09/13/2012
Submitted Date	09/13/2012

Dear Rosalind Minor,

Introduction:

Thank you for your time in review of this filing.

Response 1

Comments:

An additonal fee of $325.00 has been submitted via EFT.

Related Objection 1

Applies To:

- *Group Policy - Hospital Confinement Indemnity, B 20620 MP-E (Form)*
- *Certificate of Insurance - Hospital Confinement Indemnity, B 20620 CRT-E (Form)*
- *Optional Benefit - Daily Hospital Confinement, B 20620 CRT-E OPB1 (Form)*
- *Optional Benefit - First Day Hospital Confinement, B 20620 CRT-E OPB2 (Form)*
- *Optional Benefit - Emergency Accident, B 20620 CRT-E OPB8 (Form)*
- *Optional Benefit - Physician's Office Visit, B 20620 CRT-E OPB9 (Form)*
- *Optional Benefit - Surgical Indemnity, B 20620 CRT-E OPB10 (Form)*
- *Optional Benefit - Health Screening, B 20620 CRT-E OPB11 (Form)*
- *Employer Agreement, B 0214 CA (Form)*
- *Enrollment Form, B 0214 EDF2012 (Form)*

Comments:

Our filing fees under Rule and Regulation 57 have been updated. Please review the General Instructions for ArkansasLH or Rule and Regulation 57.

The fee for this submission is $50.00 per form for a total of $500.00. Please submit an additional $325.00 for this submission.

We will begin our review of this submission upon receipt of the additional filing fee.

Changed Items:

No Supporting Documents changed.

No Form Schedule items changed.

No Rate/Rule Schedule items changed.

Conclusion:

Sincerely,
Tina Cunningham

SERFF Tracking #:	*BFLI-128600035*	***State Tracking #:***		***Company Tracking #:***	*AR B 20620 MP-E*

State:	*Arkansas*	***Filing Company:***	*Bankers Fidelity Life Insurance Company*
TOI/Sub-TOI:	*H14G Group Health - Hospital Indemnity/H14G.000 Health - Hospital Indemnity*		
Product Name:	*Group Hospital Indemnity*		
Project Name/Number:	*/*		

Amendment Letter

Submitted Date: 09/10/2012

Comments:

In error the actuarial memorandum was left off Form Schedule.

Changed Items:

Supporting Document Schedule Item Changes:

User Added -Name: Actuarial Memorandum

Comment:

B 20620 MP-E & CRT-E Act Memo NYC 06-22-2012.pdf

State: *Arkansas* **Filing Company:** *Bankers Fidelity Life Insurance Company*
TOI/Sub-TOI: *H14G Group Health - Hospital Indemnity/H14G.000 Health - Hospital Indemnity*
Product Name: *Group Hospital Indemnity*
Project Name/Number: */*

Note To Reviewer

Created By:

Tina Cunningham on 10/15/2012 03:07 PM

Last Edited By:

Tina Cunningham

Submitted On:

10/15/2012 03:07 PM

Subject:

Arbitration Provision

Comments:

Good day Ms Minor. In error I did not correct the table of contents to remove the Arbitration Provision. Is there a way that you can reopen this filing to allow me to submit the necessary correction?

State: Arkansas **Filing Company:** Bankers Fidelity Life Insurance Company
TOI/Sub-TOI: H14G Group Health - Hospital Indemnity/H14G.000 Health - Hospital Indemnity
Product Name: Group Hospital Indemnity
Project Name/Number: /

Note To Filer

Created By:

Rosalind Minor on 10/15/2012 01:13 PM

Last Edited By:

Rosalind Minor

Submitted On:

10/15/2012 02:22 PM

Subject:

Objection Letter of 9/14/12

Comments:

I have not received a response to my Objection Letter of 9/14/12. Do you need additional time to respond?

SERFF Tracking #:	*BFLI-128600035*	***State Tracking #:***		***Company Tracking #:***	*AR B 20620 MP-E*

State:	*Arkansas*	***Filing Company:***	*Bankers Fidelity Life Insurance Company*
TOI/Sub-TOI:	*H14G Group Health - Hospital Indemnity/H14G.000 Health - Hospital Indemnity*		
Product Name:	*Group Hospital Indemnity*		
Project Name/Number:	*/*		

Form Schedule

Lead Form Number: B 20620 MP-E

Item No.	Schedule Item Status	Form Number	Form Type	Form Name	Action/ Action Specific Data	Readability Score	Attachments
1	Approved-Closed 10/15/2012	B 20620 MP-E	POL	Group Policy - Hospital Confinement Indemnity	Initial:	46.300	B 20620 MP-E AR.pdf
2	Approved-Closed 10/15/2012	B 20620 CRT-E	CER	Certificate of Insurance - Hospital Confinement Indemnity	Initial:	52.100	B 20620 CRT-E.pdf
3	Approved-Closed 10/15/2012	B 20620 CRT-E OPB1	CERA	Optional Benefit - Daily Hospital Confinement	Initial:	52.100	B 20620 CRT-E OPB1.pdf
4	Approved-Closed 10/15/2012	B 20620 CRT-E OPB2	CERA	Optional Benefit - First Day Hospital Confinement	Initial:	52.100	B 20620 CRT-E OPB2.pdf
5	Approved-Closed 10/15/2012	B 20620 CRT-E OPB8	CERA	Optional Benefit - Emergency Accident	Initial:	52.100	B 20620 CRT-E OPB8.pdf
6	Approved-Closed 10/15/2012	B 20620 CRT-E OPB9	CERA	Optional Benefit - Physician's Office Visit	Initial:	52.100	B 20620 CRT-E OPB9.pdf
7	Approved-Closed 10/15/2012	B 20620 CRT-E OPB10	CERA	Optional Benefit - Surgical Indemnity	Initial:	52.100	B 20620 CRT-E OPB10.pdf
8	Approved-Closed 10/15/2012	B 20620 CRT-E OPB11	CERA	Optional Benefit - Health Screening	Initial:	52.100	B 20620 CRT-E OPB11.pdf
9	Approved-Closed 10/15/2012	B 0214 CA	AEF	Employer Agreement	Initial:	46.300	B 0214 CA (6-12).pdf
10	Approved-Closed 10/15/2012	B 0214 EDF2012	AEF	Enrollment Form	Initial:	45.600	B 0214 EDF2012.pdf

Form Type Legend:

ADV	Advertising	**AEF**	Application/Enrollment Form

State: Arkansas **Filing Company:** Bankers Fidelity Life Insurance Company
TOI/Sub-TOI: H14G Group Health - Hospital Indemnity/H14G.000 Health - Hospital Indemnity
Product Name: Group Hospital Indemnity
Project Name/Number: /

CER	Certificate	**CERA**	Certificate Amendment, Insert Page, Endorsement or Rider
DDP	Data/Declaration Pages	**FND**	Funding Agreement (Annuity, Individual and Group)
MTX	Matrix	**NOC**	Notice of Coverage
OTH	Other	**OUT**	Outline of Coverage
PJK	Policy Jacket	**POL**	Policy/Contract/Fraternal Certificate
POLA	Policy/Contract/Fraternal Certificate: Amendment, Insert Page, Endorsement or Rider	**SCH**	Schedule Pages

BANKERS FIDELITY LIFE INSURANCE COMPANY

4370 Peachtree Road, N.E., Atlanta, Georgia 30319

GROUP POLICY
LIMITED BENEFIT HOSPITAL CONFINEMENT INDEMNITY COVERAGE

Group Policyholder:	{ABC GROUP}	Group Policy Effective Date:	{04-01-2007}
Group Policy Number:	{005-1234567}	State of Delivery:	{AR}
Premiums due on:	1st of each month following Group Policy Effective Date	First Renewal Date:	{04-01-2008}

Minimum Participation Requirement: {50%}

Bankers Fidelity Life Insurance Company (hereinafter referred to as "We", "Our", "Us" or "the Company") promises, subject to the terms of this Group Policy, to insure Insured Persons of the Group Policyholder under this Group Policy. We make this promise in consideration of the application for this Group Policy and payment of the required premium. This Group Policy replaces any previous policy issued to the Group Policyholder for the coverage described in the Certificate of Insurance.

This Group Policy becomes effective at 12:01 a.m., Standard Time on the Group Policy Effective Date in the State of Delivery specified above. Subject to the terms and conditions of this Group Policy, it can be renewed upon the First Renewal Date by the timely payment of the required premium. Unless terminated in accordance with the applicable provisions of this Group Policy, it can be subsequently renewed on an annual basis, subject to the terms and conditions of this Group Policy, by timely payment of the required premium. Provided, however, that we reserve the right to non-renew.

This Group Policy may be modified by mutual agreement between the Group Policyholder and Us.

The provisions on the following pages and the terms in the Certificate of Insurance are part of this Group Policy. A copy of the Certificate of Insurance is attached to, and made a part of this Group Policy.

Signed for us in Atlanta, Georgia.

Vice President

President

TABLE OF CONTENTS

PREMIUMS

We provide insurance coverage in return for premium payment. The first premium payment is due on the Effective Date shown on the front page of this Group Policy. All other premiums are due on the first day of each calendar month thereafter.

PREMIUM SUBJECT TO CHANGE - We may change the premium rates. A change will apply to all Certificates of Insurance issued under this Group Policy. A change in premium rate will first take effect on the First Renewal Date of this Group Policy. Subsequent changes in premium rates will take effect on subsequent renewal dates. A minimum of thirty (30) days written notice will be given.

PREMIUM PAYMENT - All premiums, including adjustments, must be paid to Us in advance. These premiums are due as shown on the first page of this Policy. The payment of any premium shall not continue this Group Policy or any Certificate of Insurance in force beyond the next premium due date, except as provided in the Grace Period provision.

GRACE PERIOD - This Group Policy has a thirty-one (31) day Grace Period. This means that if a premium is not paid on or before the date it is due, it may be paid during the following thirty-one (31) days. During the Grace Period this Group Policy and the Certificates of Insurance issued under it will remain in force. If the premium is not paid by the end of this Grace Period, this Group Policy and the Certificates of Insurance issued under it will terminate. If we receive written notice during the Grace Period that the Group Policy is to be canceled, We will cancel it as of the date requested, provided the date is before the expiration of the Grace Period. The Group Policyholder will be liable to Us for the payment of all premiums due and owing upon cancellation or termination, including the premium for the Grace Period.

GENERAL PROVISIONS

ENTIRE CONTRACT - This Group Policy, including any endorsements, amendments and riders, the Group Policyholder application, the Certificate of Insurance, if any, attached to this Group Policy are the entire contract between You and Us. All statements made in the application shall, in the absence of fraud, be deemed representations and not warranties.

CHANGES - No agent may change this Group Policy or waive any of its provisions. No agent has authority to make a statement or promise that binds Us. No change in this Group Policy will be effective until it is approved by one of Our executive officers. This approval must be noted on or attached to this Group Policy.

STATEMENTS MADE BY GROUP POLICYHOLDER - All statements made by the Group Policyholder in the application for this Group policy, except fraudulent misstatements or intentional misrepresentations of material fact, shall be deemed representations and not warranties. No statement made by the Group Policyholder shall be used to avoid the Group Policy or reduce benefits, unless the statement is contained in a written instrument signed by the Group Policyholder and attached to this Group Policy.

TIME LIMIT ON CERTAIN DEFENSES - No misstatements, except fraudulent misstatements, made by the Group Policyholder in the attached application for such Group Policy shall be used to rescind or void the Group Policy after two (2) years from the Effective Date. All statements made in the application shall, in the absence of fraud, be deemed representations and not warranties.

AMENDMENT OF GROUP POLICY - Upon written notice, We may amend or modify the terms and conditions of this Policy. Any such amendment or modification will only be effective upon the next renewal of the Group Policy. If this Group Policy is amended so as to modify coverage for any Insured Persons, such modifications shall also apply in the same manner to Insured Persons whose coverage is continued hereunder.

MINIMUM PARTICIPATION REQUIREMENT - We may establish Minimum Participation Requirement(s). Such requirements, if any, are shown on the front page of this Group Policy. For purposes of determining whether the Minimum Participation Requirements under this Group Policy have been fulfilled, We will look to the number of the Group Policyholder's Eligible Members whose enrollment applications are accepted for Coverage. An Eligible Member is an employee who (1) is directly employed by Group Policyholder for pay in the conduct of Group Policyholder's regular business; (2) works at least 20 hours each week at the Group Policyholder's regular place of business; and (3) has been employed for more than 30 days by the Group Policyholder. Eligible Member does not mean a temporary employee.

In the event the Minimum Participation Requirement is not met, We, at any time, may cancel the Group Policy upon sixty (60) days' written notice. Such notice shall be made by delivering the notice in person to the Group Policyholder or by depositing the notice in the United States mails to be dispatched by at least first-class mail to the last address of record of the Group Policyholder and receiving the receipt provided by the United States Postal Service or such other evidence of mailing as prescribed or accepted by the United States Postal Service.

ENROLLMENT - An Eligible Employee may enroll for Coverage under the Group Policy within ten (10) days upon qualifying as an Eligible Employee. Eligible Employees who fail to enroll or otherwise decline Coverage may thereafter enroll during the Open Enrollment Period. Provided, however, that should an Insured Person terminate Coverage and wish to re-enroll at a later date, we reserve the right to require a minimum of one year before said Insured Person may re-enroll. An Eligible Employee shall become an Insured Member on the first day of the month following the acceptance of the Eligible Employee's enrollment application.

REPLACEMENT OF PRIOR GROUP POLICY - If this Group Policy replaces another similar group policy issued to the Group Policyholder, all persons covered under the prior group policy, on its date of termination, will be covered under this Group Policy, subject to the Minimum Participation Requirement and the Payment of Premium.

CHANGES IN ENROLLMENT, RECORDS, AND REPORTS - Group Policyholder must keep records sufficient to detail each Insured Member's insurance under the Group Policy and related Certificates of Insurance which records We have the right to audit, review, and inspect upon reasonable notice. Group Policyholder is responsible for supplying Eligible Employees with an enrollment application upon qualifying as an Eligible Employee and during the Open Enrollment Period. All changes in an Insured Person's eligibility for Coverage under the Group Policy, including ineligibility, must be reported to Us on a monthly basis. Retroactive adjustments may be made for any changes to eligibility which are not known at the time the premium is billed.

CERTIFICATE OF INSURANCE PROVISIONS MADE A PART OF THIS GROUP POLICY - The remainder of the Group Policy consists of the provisions shown in the Certificate of Insurance issued to Insured Members under this Group Policy. Amendment and riders, if any, changing the provisions of the Certificate of Insurance are also made a part of this Group Policy. We will deliver the Certificate of Insurance to Insured Members.

TERMINATION OF THIS GROUP POLICY - In addition to our right to cancel the Group Policy as stated in the Grace Period and Minimum Participation Requirement provisions, We may terminate this Group Policy at any time following the First Renewal Date by giving the Group Policyholder sixty (60) days advance written notice. Such notice shall be made by delivering the notice in person to the Group Policyholder or by depositing the notice in the United States mails to be dispatched by at least first-class mail to the last address of record of the Group Policyholder and receiving the receipt provided by the United States Postal Service or such other evidence of mailing as prescribed or accepted by the United States Postal Service. The Group Policyholder may also terminate the Group Policy by giving Us written notice at least sixty (60) days before the intended termination date.

ADDITIONAL PROVISIONS

CONFORMITY WITH STATE STATUTES - Any provision of this Group Policy which, on its Effective Date is in conflict with the laws of the State in which it was issued, will be amended on that date to conform to the minimum requirements of such laws.

ERISA - If this Group Policy is being purchased to provide Group Policyholder's employees and dependents benefits under a Welfare plan governed by the Employee Retirement Security Act (ERISA, 29 U.S.C. § 1001, et seq.), then We are not the plan administrator, the Plan Sponsor, nor are We a plan fiduciary.

THE BACK COVER IS ON THE REVERSE OF THIS PAGE.

THIS PAGE LEFT INTENTIONALLY BLANK.

BANKERS FIDELITY LIFE INSURANCE COMPANY

4370 Peachtree Road, N.E., Atlanta, Georgia 30319

GROUP POLICY
LIMITED BENEFIT HOSPITAL CONFINEMENT INDEMNITY COVERAGE

BANKERS FIDELITY LIFE INSURANCE COMPANY

4370 Peachtree Road, N.E., Atlanta, Georgia 30319

CERTIFICATE OF INSURANCE
LIMITED BENEFIT HOSPITAL CONFINEMENT INDEMNITY COVERAGE

Group Policyholder:	{NAME}	Certificate Number:	{NUMBER}
Group Policy Number:	{NUMBER}	Certificate Effective Date:	{DATE}

THIS IS A LIMITED CERTIFICATE - PLEASE READ THIS CERTIFICATE CAREFULLY!

Bankers Fidelity Life Insurance Company (hereinafter referred to as "We," "Our," "Us," or "the Company") promises to provide the Insured Persons with the benefits described in this Certificate, subject to the terms of the Group Policy issued to the Group Policyholder. We make this promise in consideration of the application for this Certificate and the payment of the required Premium. This Certificate replaces any previous certificate of insurance issued for the coverage described in this Certificate.

THIS IS NOT AN INSURANCE CONTRACT BETWEEN THE INSURED MEMBER AND US - This Certificate does not constitute an insurance contract between the Insured Member and Us. It merely explains the features of the Group Policy We have issued to the Group Policyholder. All of the Insured Persons rights and benefits will be determined solely by the provisions of the Group Policy. A copy of the Group Policy may be examined in the Group Policyholder's office at any reasonable time.

The insurance under the Group Policy does not take the place of nor does it affect any requirements for coverage by Workers Compensation or similar type of insurance.

Signed for us in Atlanta, Georgia.

Vice President

President

IMPORTANT CANCELLATION INFORMATION
PLEASE READ THE PROVISION ENTITLED "WHEN COVERAGE ENDS" FOUND ON PAGE 9.

LIMITED BENEFIT HOSPITAL CONFINEMENT INDEMNITY COVERAGE
NON-PARTICIPATING
CONTRIBUTORY

TABLE OF CONTENTS

BANKERS FIDELITY LIFE INSURANCE COMPANY

4370 Peachtree Road, N.E., P.O. Box 105185, Atlanta, Georgia 30348-5185

For inquiries or to make a complaint, please contact the Policyholder Service Department at:
Direct (404) 266-5730; Toll-free (866) 458-7500; email bfphs@atlam.com

SPECIFICATIONS PAGE
Limited Benefit Hospital Confinement Indemnity Coverage

Certificate Form B 20620 CRT-E

Insured Person(s)

Insured Person(s):	Relationship to Insured:	Issue Age:	Sex:	Effective Date:
{NAME}	INSURED MEMBER	{AGE}	{SEX}	{EFFECTIVE DATE}
{NAME}	{RELATIONSHIP}	{AGE}	{SEX}	{EFFECTIVE DATE]
{NAME}	{RELATIONSHIP}	{AGE}	{SEX}	{EFFECTIVE DATE]
{NAME}	{RELATIONSHIP}	{AGE}	{SEX}	{EFFECTIVE DATE]
{NAME}	{RELATIONSHIP}	{AGE}	{SEX}	{EFFECTIVE DATE]
{NAME}	{RELATIONSHIP}	{AGE}	{SEX}	{EFFECTIVE DATE]
{NAME}	{RELATIONSHIP}	{AGE}	{SEX}	{EFFECTIVE DATE]
{NAME}	{RELATIONSHIP}	{AGE}	{SEX}	{EFFECTIVE DATE]
{NAME}	{RELATIONSHIP}	{AGE}	{SEX}	{EFFECTIVE DATE]
{NAME}	{RELATIONSHIP}	{AGE}	{SEX}	{EFFECTIVE DATE]
{NAME}	{RELATIONSHIP}	{AGE}	{SEX}	{EFFECTIVE DATE]

Benefits

Base Plan Benefits:	Insured	Spouse	Each Child*	All Children*
DAILY HOSPITAL CONFINEMENT BENEFIT:	[$30 - $1,000; $10 units]			
CALENDAR YEAR MAXIMUM*:	[$900 - $30,000; children 2x Insured for all combined)			

*The Calendar Year Maximum benefit for all covered children combined is equal to twice the Calendar Year Maximum for an individual child.

Optional Benefits (if chosen and indicated below):

{ADDITIONAL DAILY HOSPITAL CONFINEMENT BENEFIT}
{FIRST-DAY HOSPITAL CONFINEMENT BENEFIT}
{PHYSICIAN'S OFFICE VISIT BENEFIT}
{SURGICAL INDEMNITY BENEFIT}
{HEALTH SCREENING BENEFIT}
{EMERGENCY ACCIDENT BENEFIT}

Certificate Identification

Certificate Number: 005-{Fld0004}

PAGE 3 IS ON THE REVERSE OF THIS PAGE.

THIS PAGE LEFT INTENTIONALLY BLANK.

DEFINITIONS

When We use the following words this is what We mean:

AGE - The Age of the Insured Person at their last birthday.

CALENDAR YEAR MAXIMUM - the total amount payable under this Certificate for a specified benefit, as shown on Page 3 for a Calendar Year. Once We have paid the Calendar Year Maximum benefit no further benefits will be payable under this Certificate for the remainder of the Calendar Year.

A "Calendar Year" is the period beginning at 12:00 a.m. Standard Time January 1st and ending at 11:59 p.m. Standard Time December 31st.

COMPLICATIONS OF PREGNANCY - normally covered as any other sickness including such involuntary complications as eclamptic toxemia; hyperemesis gravidarum; placenta praevia; ectopic pregnancy; puerperal infection; pre eclampsia; eclampsia; and miscarriage. For a Complication Of Pregnancy to be covered, the pregnancy must commence after the Effective Date of the Certificate.

The following Complications Of Pregnancy are not covered: 1) false labor; 2) occasional spotting; 3) Physician prescribed rest during the pregnancy; or 4) other conditions which are not a distinct Complication Of Pregnancy, even though they may be connected with the management of a difficult pregnancy.

CONFINEMENT - admittance to a Hospital on an in-patient basis as a resident bed patient for which a charge for room and board is made on a daily basis. Observation, emergency or out-patient rooms are not considered Confinement.

COVERAGE - the right of an Insured Person to receive benefits under the Group Policy, subject to its terms, conditions, limitations, and exclusions.

COVERED INJURY - bodily injury caused by an accident. The accident causing the injury must occur while this Certificate is in force. The injury must be the direct cause of loss. The loss must be independent of any sickness, disease, bodily infirmity or any other causes. An injury includes all injuries as a result of one (1) accident.

COVERED SICKNESS - illness, disease, pregnancy or Complication Of Pregnancy which occurs while this Certificate is in force. A sickness is considered to begin when the condition is diagnosed by, or medical advice or treatment is recommended by or received from, a Physician.

CREDIBLE COVERAGE - insurance benefits provided for sickness and injury under an individual or group insurance policy or health benefit plan, medical expense policy, or state, federal or government-sponsored insurance program. The prior insurance benefits must not have terminated more than sixty-three (63) days before the Effective Date of this Certificate.

DAILY HOSPITAL CONFINEMENT BENEFIT - the amount of benefit We will pay for each day of Hospital Confinement as shown on Page 3.

ELIGIBLE MEMBER(S) - (1) an employee who (a) is directly employed by the Group Policyholder for pay in the conduct of the Group Policyholder's regular business, and (b) works at least 20 hours each week at the Group Policyholder's regular place of business, and (c) has been employed for more than 30 days by the Group Policyholder. Eligible Member does not mean a temporary or leased employee.

DEFINITIONS, continued

ELIGIBLE DEPENDENT(S) - (1) the Insured Member's: (a) lawful spouse; (b) unmarried natural child or step-child, or grandchild for whom the Insured Member has been granted guardianship or custody, from birth up to and including age 25 years, or (c) unmarried child at least 25 years of age who: (i) is primarily dependent upon the Insured Member for support because he or she is incapable of self-sustaining employment by reason of mental retardation or a physical handicap; (ii) was incapacitated and insured under this Certificate on the child's 25th birthday; and (iii) continues to be incapacitated beyond the child's 25th birthday; or (2) a child for whom the Insured Member must provide medical support; or (3) a child for whom the Insured Member is a party in a suit for adoption of such child;.

EMERGENCY ROOM; ACUTE CARE CENTER - a unit of a Hospital or ambulatory surgical center that is set aside from the rest of the Hospital or ambulatory surgical center facilities and designated and billed by the Hospital or ambulatory surgical center as an Emergency Room or Acute Care Center and has ready on an immediate basis the special life-saving equipment and supplies necessary for the treatment of critically and seriously injured patients who require immediate medical attention.

Emergency Room or Acute Care Center does not mean the in-patient rooms or observation rooms of a Hospital or the routine treatment or surgical rooms of an ambulatory surgical center.

GROUP POLICY - The group insurance policy issued to the Group Policyholder.

GROUP POLICYHOLDER - The entity named as the Group Policyholder on the front page of this Certificate.

HOSPITAL - a place which: 1) is legally operated for the care and treatment of sick and injured persons at their expense; 2) is primarily engaged in providing medical, diagnostic and surgical facilities (either on its premises or in facilities available to the hospital on a formal prearranged basis); 3) has continuous twenty four (24) hour Nursing Services by or under the supervision of registered graduate professional nurses (R.N.); and 4) has staff of a least one (1) Physician available at all times.

"Hospital" does not mean a convalescent, nursing, rest, long term care, mental or skilled nursing facility. It does not mean a place primarily operated for treatment of the aged, mentally ill, drug addicts, alcoholics or tuberculosis patients, nor a special unit of a hospital used by or for any of the above.

INSURED MEMBER - the Eligible Employee who is at least 18 years of Age, and whose enrollment application has been approved.

INSURED PERSON(S) - the Insured Member and Eligible Dependents; also referred to as "You," "Your," or "Yours."

INTENSIVE CARE UNIT - a unit of a Hospital that is: 1) set aside from the rest of the Hospital facilities for critically and seriously ill or injured patients who require audio visual observation as prescribed by the attending Physician; and 2) a place where the following are available on an immediate and stand by basis: a) room and board; b) specialized registered nurse and other Nursing Services; and c) special life-saving equipment and supplies.

LOSS - the specific risk or insurable event for which coverage is provided under this Certificate.

MEDICALLY NECESSARY - a treatment, service or supply which is broadly accepted by the medical profession as appropriate and essential in the diagnosis or treatment of a sickness or injury and is based on generally recognized and accepted standards of health care. We have the right to obtain, at Our own expense, the opinion of a Physician of Our choice in case of a dispute regarding medical necessity.

DEFINITIONS, continued

MEDICARE - the Health Insurance for the Aged Act under the Title XVIII of the United States Social Security Act of 1965, as then constituted or as later amended.

MENTAL OR NERVOUS DISORDER - any mental or emotional disease or disorder without demonstrable organic cause, including but not limited to: neurosis, psychoneurosis, psychopathy, psychosis or any mental or emotional disease or disorder.

NURSING SERVICES - services that are provided by a registered nurse (R.N.), licensed practical nurse (L.P.N.) or a licensed vocational nurse (L.V.N.) who is: 1) acting within the scope of that person's license; 2) authorized by a Physician to perform such services; and 3) not the Insured's spouse, child, parent or anyone related to the Insured by blood or marriage or one who normally lives with the Insured.

OPEN ENROLLMENT PERIOD - the thirty (30) day period prior to the next renewal date of the Group Policy.

PHYSICIAN - any duly licensed person practicing in the healing arts, other than You or Your spouse. The Physician must be acting within the scope of his or her license.

PHYSICIAN'S OFFICE - the primary business location of the Physician, including locations such as a free-standing office, physician's complex or emergency medical clinic.

A Physician's Office does not include a business location which is in or directly affiliated with or operated by a Hospital, Ambulatory Surgical Center, nursing facility or facility primarily operated for the treatment of the mentally ill, drug addicts or alcoholics.

PHYSICIAN'S OFFICE VISIT - consultation with or examination by a Primary Care Physician in the Physician's Office for the evaluation of a Covered Injury or Covered Sickness to determine the appropriate course of medical treatment for the Covered Injury or Covered Sickness.

PRE-EXISTING CONDITIONS - a medical condition for which: 1) medical advice or treatment was recommended by, or received from, a Physician within the one (1) year period before the Effective Date; or 2) symptoms existed within the one (1) year period before the Effective Date which would cause an ordinarily prudent person to seek diagnosis, care or treatment.

PRIMARY CARE PHYSICIAN - a Physician trained in general medical types of patient care, including those in family practice, general practice, pediatrics, obstetrics or gynecology and internal medicine who typically provide comprehensive, continuing care to a patient, including health promotion, disease prevention, health maintenance, counseling, patient education, diagnosis and treatment of acute and chronic illnesses and coordination of care with other Physicians specializing in specific diseases or conditions.

RENEWAL DATE - the annual anniversary of the Group Policy's Effective Date.

SURGICAL ROOM - a unit of a Physician's office, Hospital or ambulatory surgical center that is: 1) set aside from the rest of the facilities for the purpose of performing surgical operations; 2) specially equipped with equipment and supplies necessary to perform surgical operations; and 3) designated and billed by the facility as a "Surgical Room" or "operating room".

PRE-EXISTING CONDITIONS LIMITATION

Losses incurred for Pre-existing Conditions are not covered until one (1) year after the Effective Date of coverage.

CREDIT FOR PRIOR CREDIBLE COVERAGE - The Pre-existing Conditions Limitation provision will be waived to the extent an Insured Person had met the limitation period for the same benefit under prior Credible Coverage.

BENEFITS PROVIDED UNDER THIS CERTIFICATE

We will pay benefits for Losses that are: 1) incurred for a Covered Injury occurring after the Effective Date and while this Certificate is in force; 2) incurred for a Covered Sickness occurring while this Certificate is in force; and, 3) Medically Necessary. Insured Persons under the Group Policy are entitled to the following benefits:

DAILY HOSPITAL CONFINEMENT BENEFIT - We will pay the Daily Hospital Confinement Benefit, up to the Calendar Year Maximum shown on Page 3, for each day of Confinement to a Hospital.

OPTIONAL BENEFITS - Insured Persons under the Group Policy are entitled to the Optional Benefits described on the following pages, if the benefits were chosen by the Eligible Member, issued by the Company and indicated on Page 3.

EXCLUSIONS

No Benefits are provided for the following, nor will We pay any expenses incurred as a result of any Loss which is caused, sustained or incurred, directly or indirectly, by or for any of the following:

1. dental x rays or services, except when Medically Necessary because of an accidental injury to sound, natural teeth while this Certificate is in force, and the Loss is incurred within six (6) months of Covered Injury;
2. war, or any act of war, declared or undeclared, or any armed conflict;
3. while You are committing or attempting to commit a felony, or while being engaged in an illegal occupation, riot, or insurrection;
4. while You are incarcerated, confined or detained by any foreign or domestic governmental authorities;
5. when the Loss is covered by, and benefits are paid for the Loss under, Workers' Compensation, Employees' Liability Law, Occupational Disease Law, or similar law;
6. incurred for the cost of care, service or supplies that are covered under any national, state or other government plan, except Medicaid;
7. for services for which no charge is normally made in the absence of insurance, including Veterans' Hospitals;
8. for services rendered or supplies received outside the United States, its possessions, or Canada, except for emergency admission or acute onset of sickness or injury sustained while traveling for business or pleasure;
9. due to mental or nervous disorder unless organically demonstrable;
10. resulting from the Insured Person being under the voluntary influence of alcohol or a controlled substance (other than Physician-prescribed drugs);
11. caused by attempted suicide or any intentionally self-inflicted injury, while sane or insane;
12. resulting from cosmetic surgery, including, but not limited to, breast augmentation or reduction or removal of excess tissue or skin after gastric bypass surgery, except the necessary care and treatment of medically diagnosed congenital defects and birth abnormalities;
13. treatment for infertility, test tube fertilization, sex transformation, artificial insemination, elective termination of pregnancy or any operation or procedure that alters the body (male or female) for the purpose of temporary or permanent prevention of pregnancy or the reversal of such procedure;
14. radial keratotomy, eye refractions, hearing aids, eye glasses, contact lenses, or the fitting thereof unless due to Covered Injury;
15. for weight modification or surgical treatment of obesity, including all forms of intestinal bypass surgery (except when Medically Necessary);
16. for Losses incurred while the Group Policy or this Certificate is not in force, except as provided in the Extension of Benefits provision of this Certificate.

CONDITIONS FOR COVERAGE

WHEN COVERAGE STARTS - Eligible Members are covered at 12:00 a.m. Standard Time on the first day of the month coincident with or following the date he or she becomes an Insured Member.

Eligible Dependents are covered on the date the Insured Member's Coverage becomes effective. If the Insured Member does not have any Eligible Dependents on the date his or her coverage becomes effective, coverage for an Eligible Dependent of the Insured Member will become effective at 12:00 a.m. Standard Time on the first day of the month coincident with or following the date the Insured Member acquires an Eligible Dependent, except for newborn and adopted children.

Coverage for a newborn child is effective on the date of birth of such child and continues for thirty (30) days. Coverage for an adopted child is effective on the date the Insured Member becomes a party to a suit to the adoption and continues for thirty (30) days. Coverage for a newborn child or adopted child will continue past the first thirty (30) days provided (i) the Insured Member provides Us with written notice within the first thirty (30) days of Coverage of Insured Member's intention to continue Coverage for the newborn or adopted child past the initial thirty (30) day period; and (ii) the Group Policyholder has paid any additional required premium for such child within the first thirty (30) day period.

WHEN COVERAGE ENDS - Coverage for the Insured Person will end automatically at 11:59 p.m. Standard Time on the last day of the month in which the Insured Member is no longer an Eligible Member as defined; or on the date the Group Policy terminates, whichever is earlier.

Coverage for any insured Eligible Dependent will end automatically at 11:59 p.m. Standard Time on the last day of the month in which an Eligible Dependent is no longer an Eligible Dependent as defined; or on the date the Group Policy terminates, whichever is earlier. For an adopted child, no longer being an Eligible Dependent as defined also means the date the child is removed from placement prior to legal adoption.

Termination of coverage shall be without prejudice to any loss commencing while this Certificate was in force.

VOLUNTARY TERMINATION OF INSURANCE - If You terminate Your Coverage and wish to re-enroll at a later date, We reserve the right to require a minimum of one year before You may re-enroll. You may only re-enroll during the next Open Enrollment Period after the one year has expired. This one year time period will begin on the date You first terminated Your Coverage. Voluntary termination will include termination of coverage due to non-payment of premium. Re-enrollment can only be pursued during an Open Enrollment Period.

TERMINATION

This Certificate will terminate on the first Certificate anniversary date on or after the Insured Members 70th birthday.

Termination of coverage shall be without prejudice to any loss commencing while this Certificate was in force. However, We reserve the right to deduct any premium due from benefits paid.

EXTENSION OF BENEFITS - If an Insured Person is receiving benefits for a Hospital Confinement that began prior to the date the Certificate would otherwise terminate, and continues beyond the date the Certificate would otherwise terminate, coverage for that Confinement will continue during that period of continuous Confinement for that Insured Person, including benefits that would also normally be payable for covered Losses incurred during that same period of continuous Confinement. The Certificate will terminate when the Confinement ends, or when benefits no longer are payable for that period of Confinement.

GENERAL PROVISIONS

COORDINATION OF BENEFITS - We will not coordinate benefits provided under Your Group Certificate and another medical plan under which the Insured Person may be covered.

TIME LIMIT ON CERTAIN DEFENSES - All statements made by the Eligible Member in the application for this Certificate, except fraudulent misstatements or intentional misrepresentations of material fact, shall be deemed representations and not warranties. No statement made by the Eligible Member shall be used in defense of a claim under the Certificate after two (2) years from the Insured Member's enrollment unless it is contained in a written application that is endorsed upon or attached to the Certificate when issued or delivered.

AMENDMENT OF CERTIFICATE - Upon written notice to the Group Policyholder, We may amend or modify the terms and conditions by which You may obtain benefits, including but not limited to amending or modifying the definition of Eligible Members or the Minimum Participation Requirement. Any such amendment or modification will only be effective upon the next renewal of the Group Policy.

OTHER INSURANCE WITH US - You may have only one (1) Limited Benefit Hospital Confinement Indemnity Certificate issued by Us under the Group Policy. If through error, You are issued more than one (1) such Certificate, We will cancel the duplicate Certificate and refund any unearned premium.

CLAIM PROVISIONS

NOTICE OF CLAIMS - Written Notice of Claim must be given within twenty (20) days after a covered Loss begins or as soon as possible. The notice can be given to Us at Our Home Office, at the address shown on Page 3, or to any one of Our authorized agents. The notice should include Your name and the number of the Certificate.

CLAIM FORMS - When We receive Notice of Claim, We will send You forms for filing Proof of Loss, if these forms are not given to You within ten (10) days, You can meet the Proof of Loss requirements by giving Us a written statement of the nature and extent of the Loss within the time stated in the Proof of Loss provision.

PROOF OF LOSS - Written Proof of Loss must be given to Us within ninety (90) days after We send You the claim forms. If it was not reasonably possible for You to give Us proof in the time required, We shall not reduce or deny the claim for this reason if the proof is filed as soon as possible. In any event, the proof required must be given no later than one year from the time specified unless You were legally incapacitated.

TIME OF PAYMENT OF CLAIMS - All benefits payable under this Certificate will be paid as soon as We receive proper written Proof Of Loss. We may pay all or a portion of any indemnities provided for health care services to the provider, if You direct Us to do so in writing at the time Proof Of Loss is filed. We cannot require that the services be rendered by a particular provider.

PAYMENT OF CLAIM - All benefits will be paid to You, or Your assignee. Any benefits unpaid at Your death will be paid to Your named Beneficiary or Your estate if no Beneficiary is named. If benefits are payable to Your estate, We may pay up to $1,000 to any relative of Yours who We find is entitled to them. Any payment made in good faith will fully discharge Us to the extent of the payment.

CHANGE OF BENEFICIARY - If You have reserved the right to change the Beneficiary, You can file a written Request with Us to make such a change. If You have not reserved the right to change the Beneficiary, the written consent of the irrevocable Beneficiary will be required. Your Request will not be effective until it is recorded in Our home office records. After it has been so recorded, the Request will take effect as of the date You signed the Request. However, if You die before the Request has been so recorded, the Request will not be effective as to those benefits We have paid before Your Request was recorded in Our home office records.

NOTICE; WAIVER - Furnishing forms for filing Proof Of Loss, receipt of Notice Of Claim or investigation of any claim shall not waive any of Our rights in defense of any such claim.

PHYSICAL EXAMINATION AND AUTOPSY - We, at Our own expense, have the right to have You examined as often as reasonably necessary while a claim is pending. We may also have an autopsy made, unless prohibited by law.

LEGAL ACTION - No legal action may be brought to recover on this Certificate within sixty (60) days after written Proof of Loss has been given as required by this Certificate. No such action may be brought after three (3) years from the time written Proof of Loss is required to be given.

STATEMENT OF EMPLOYEE RIGHTS UNDER EMPLOYEE RETIREMENT INCOME SECURITY ACT OF 1974 (ERISA)

As a participant in the employee group plan provided by the plan sponsor (the "Plan"), You are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974. The plan administrator for Your Plan may be Your benefits committee or benefits administrator and is specified in the Plan's Summary Plan Description. Bankers Fidelity Life Insurance Company is neither Your plan sponsor nor Your plan administrator. Your Certificate of Coverage is not the Plan's Summary Plan Description. ERISA provides that all plan participants shall be entitled to:

(i) Examine, without charge, at the plan administrator's office and at other locations (worksites and union halls), all documents, including insurance contracts, collective bargaining agreements, and copies of all documents filed by the Plan with the U.S. Department of Labor, such as annual reports and plan descriptions.

(ii) Obtain copies of all Plan documents and other plan information upon written request to the plan administrator. The plan administrator may make a reasonable charge for the copies.

(iii) Receive a summary of the plan's annual financial report. The plan administrator is required by law to furnish each participant with a copy of this summary financial report.

In addition to creating rights for plan participants, ERISA imposes duties upon the people who are responsible for the operation of the employee benefit plan. The people who operate Your plan, called "fiduciaries" of the Plan, have a duty to do so prudently and in the interest of You and other plan participants and beneficiaries. Bankers Fidelity Life Insurance Company is not a fiduciary of the Plan

.

No one, including Your employer, Your union, or any other person, may fire You or otherwise discriminate against You in any way to prevent You from obtaining a welfare benefit or exercising Your rights under ERISA.

Under ERISA, there are steps You can take to enforce the above rights. For instance, if You request materials from the Plan and do not receive them within 30 days, You may file suit in a federal court against the Plan. In such a case, the court may require the plan administrator to provide the materials and pay You up to $110 a day until You receive the materials, unless the materials were not sent because of reasons beyond the control of the plan administrator. If You have a claim for benefits, which is denied or ignored, in whole or in part, You may file suit in a state or federal court, if You have exhausted the remedies provided for review of adverse benefit determinations. If it should happen that plan fiduciaries misuse the Plan's money, or if You are discriminated against for asserting Your rights, You may seek assistance from the U.S. Department of Labor, or You may file suit in a federal court.

The court will decide who should pay court costs and legal fees. If You are successful the court may order the person You have sued to pay these costs and fees. If You lose, the court may order You to pay these costs and fees, for example, if it finds Your claim is frivolous.

If You have any questions about Your plan, You should contact the plan administrator. If You have any questions about this statement or about Your rights under ERISA, You should contact the nearest Office of the Employee Benefits Security Administration, U.S. Department of Labor, listed in Your telephone directory or the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue, NW, Washington, D.C. 20210.

PAGE 12 IS ON THE REVERSE OF THIS PAGE.

THIS PAGE LEFT INTENTIONALLY BLANK.

THE BACK COVER IS ON THE REVERSE OF THIS PAGE.

THIS PAGE LEFT INTENTIONALLY BLANK.

BANKERS FIDELITY LIFE INSURANCE COMPANY

4370 Peachtree Road, N.E., Atlanta, Georgia 30319

CERTIFICATE OF INSURANCE
LIMITED BENEFIT HOSPITAL CONFINEMENT INDEMNITY COVERAGE

THIS IS A LIMITED CERTIFICATE - PLEASE READ THIS CERTIFICATE CAREFULLY!

IMPORTANT CANCELLATION INFORMATION
PLEASE READ THE PROVISION ENTITLED "WHEN COVERAGE ENDS" FOUND ON PAGE 9.

LIMITED BENEFIT HOSPITAL CONFINEMENT INDEMNITY COVERAGE
NON-PARTICIPATING
CONTRIBUTORY

OPTIONAL BENEFIT
ADDITIONAL DAILY HOSPITAL CONFINEMENT BENEFIT

We will pay the **Additional Daily Hospital Confinement Benefit of ${100 - 1000}**, up to a Calendar Year Maximum of 5 days for each Insured Person for each day of Confinement to a Hospital, when the Daily Hospital Confinement Benefit is being paid under the Certificate for the same Confinement. The Calendar Year Maximum benefit for all covered children combined is equal to twice the Calendar Year Maximum for an individual child.

B 20620 CRT-E OPB1 IS ON THE REVERSE OF THIS PAGE.

THIS PAGE LEFT INTENTIONALLY BLANK.

OPTIONAL BENEFIT
FIRST-DAY HOSPITAL CONFINEMENT BENEFIT

We will pay the **First Day Hospital Confinement Benefit of ${30 - 1000}**, up to a Calendar Year Maximum of 1 day for each Insured Person, for the first day of each Confinement to a Hospital, when the Daily Hospital Confinement Benefit is being paid under the Certificate for the same Confinement. The Calendar Year Maximum benefit for all covered children combined is equal to twice the Calendar Year Maximum for an individual child.

B 20620 CRT-E OPB2 IS ON THE REVERSE OF THIS PAGE.

THIS PAGE LEFT INTENTIONALLY BLANK.

OPTIONAL BENEFIT
EMERGENCY ACCIDENT

We will pay the following benefits, subject to a Calendar Year Maximum of two (2) accidents per each Insured Person. The Calendar Year Maximum benefit for all covered children combined is equal to twice the Calendar Year Maximum for an individual child.

Accidental Death and Dismemberment - We will pay the amount shown below if You incur a Loss as a result of a Covered Injury. You must: 1) sustain such Covered Injury during the term of this Certifcate; and 2) incur the Loss within ninety (90) days from the date of the Covered Injury. The Loss must have resulted directly from such Covered Injury and must be independent of all other causes.

	Insured	**Spouse**	**Children**
Accidental Death	$[10000-30000]	$[5000 - 15000]	$[1000 - 3000]
Dismemberment			
Loss of both hands, both feet or sight of both eyes	$[5000 - 15000]	$[2500 - 7500]	$[500 - 1500]
Loss of one hand and one foot	$[5000 - 15000]	$[2500 - 7500]	$[500 - 1500]
Loss of one hand, one foot or sight of one eye	$[2500 - 7500]	$[1250 - 3750]	$[250 - 750]

Loss as used for dismemberment means complete severance at or above the wrist or ankle joint. Loss in relation to sight means the complete and irrecoverable loss of sight. Not more than one of the benefits (the largest) shall be payable as a result of any one accident.

Emergency Accident Visit - We will pay the Emergency Accident Visit benefit amount shown below, subject to a Calendar Year Maximum of two (2) accidents per each Insured Person, if You receive Medically Necessary care in an Emergency Room, Acute Care Center or Physician's Office for a Covered Injury. The initial visit must occur within seventy-two (72) hours of the Covered Injury; any follow-up visits for the same Covered Injury must occur within ninety (90) days of the Covered Injury. The follow-up visits must be for the same Covered Injury as the initial visit. The Calendar Year Maximum benefit for all covered children combined is equal to twice the Calendar Year Maximum for an individual child.

Emergency Visit	**Benefit Amount**	**Maximum per Accident**
Initial Visit	${50 -150}	1 visit
Follow-Up Visits	${15 - 45}	3 visits

Ambulance - We will pay the amount shown below, subject to a Calendar Year Maximum of two (2) accidents per each Insured Person, for expenses incurred in transporting an Insured to an Emergency Room or acute care center for Medically Necessary care for a Covered Injury:

	Benefit Amount	**Calendar Year Maximum**
Ground Ambulance	${75 - 225}	Two (2) trips per year
Air Ambulance	${500 - 1500}	

The transport by Ambulance must occur within seventy-two (72) hours from the date of the Covered Injury. The Calendar Year Maximum benefit for all covered children combined is equal to twice the Calendar Year Maximum for an individual child.

B 20620 CRT-E OP8 IS ON THE REVERSE OF THIS PAGE.

THIS PAGE LEFT INTENTIONALLY BLANK.

OPTIONAL BENEFIT
PHYSICIAN'S OFFICE VISIT

We will pay the **Physician's Office Visit Benefit of ${25 units}** for each Physician's Office Visit for Medically Necessary care due to a Covered Injury or Covered Sickness, up to a Calendar Year Maximum of four (4) visits for each Insured Person. The Calendar Year Maximum benefit for all covered children combined is equal to twice the Calendar Year Maximum for an individual child.

B 20620 CRT-E OPB9 IS ON THE REVERSE OF THIS PAGE.

THIS PAGE LEFT INTENTIONALLY BLANK.

OPTIONAL BENEFITS
SURGICAL INDEMNITY BENEFIT

Surgical Expenses - We will pay the lesser of the actual charges by a surgeon or the amount shown in the Surgical Schedule when the Covered Person undergoes a surgical operation while this Certificate is in force, which has been recommended by and performed under the supervision of a Physician. Amounts payable for the most common surgical procedures are listed in the Surgical Schedule. For surgeries not listed in the schedule the amount of benefit will be commensurate with those listed. The Calendar Year Maximum benefit for all covered children combined is equal to twice the Calendar Year Maximum for an individual child.

If two (2) or more surgeries are performed on the same surgical occasion, either through the same or different incisions, We will pay for the surgery providing the largest benefit.

Anesthesia Expenses - We will pay the lesser of the actual charge made by the anesthesiologist or [25]% of the surgical benefit paid.

Surgical Schedule - Amounts payable for the most common surgical procedures are listed in the Surgical Schedule. For surgeries not listed in this Schedule the amount of benefit will be commensurate with those listed.

Surgical Benefit Amount: $[1000 units]

Procedure	**Fee Allowance (per $1,000 Surgical Benefit Amount)**
Cardiovascular System	
Coronary artery bypass, vein only:	
Single coronary venous graft	840.00
Two coronary venous grafts	900.00
Three coronary venous grafts	960.00
Four or more coronary venous grafts	1,000.00
Ligation and division and complete stripping of long and short saphenous veins	260.00
Digestive System	
Appendectomy	260.00
Cholecystectomy (removal of gallbladder)	370.00
Hemorrhoidectomy, external, complete	100.00
Hemorrhoidectomy, internal and external, simple	160.00
Repair recurrent inguinal hernia	274.00
Repair recurrent femoral hernia; reducible	274.00
Tonsillectomy and adenoidectomy, under age 12	132.00
Eyes and Ears	
Removal of secondary membranous cataract with corneoscleral section	360.00
Myringotomy including aspiration and/or eustachian tube inflation	26.00
Integumentary System	
Puncture aspiration of cyst of breast	24.00
Destruction of flat warts, molluscum contagiosum, or milia; up to 14 lesions	16.00
Destruction, all benign or other than skin tags or cutaneous vascular proliferative lesions	24.00
Destruction, malignant lesion, trunk, arms or legs; lesion diameter 0.5 cm or less	26.00
Mastectomy, simple, complete	270.00

Musculoskeletal System

Amputation, metatarsal, with toe, single	116.00
Amputation leg, through tibia and fibula	290.00
Arthroscopy, knee; with lateral release, debridement/shaving of articular cartilage	364.00
Arthroscopy, shoulder; with removal of loose body or foreign body, debridement, limited	390.00
Excision of ganglion, wrist (dorsal or volar); primary	118.00

Nervous System

Burr hole(s) or trephine, infratentorial, unilateral or bilateral	510.00
Laminectomy with exploration and/or decompression of spinal cord and/or cauda equine:	
cervical, one or two vertebral segments	700.00
lumbar, one or two vertebral segments	660.00
thoracic, one or two vertebral segments	700.00
Simple intracranial aneurysm, intracranial approach; carotid circulation	1,000.00

Reproductive System

Dilation and curettage, diagnostic and/or therapeutic (nonobstretrical)	104.00
Colposcopy of the cervix including upper/adjacent vagina; with biopsy(s) of the cervix	52.00
Hysterectomy, total abdominal	442.00
Biopsy, prostate; needle or puch, single or multiple, any approach	28.00
Prostatectomy, retropubic radical, with or without nerve sparing	520.00
Transurethral resection of prostate, first stage of two-stage resection (partial resection)	460.00

Respiratory System

Removal of lung, other than total pneumonectomy; single lobe (lobectomy)	500.00
Thoracentisis, puncture of pleural cavity for aspiration, initial or subsequent	40.00

Urinary System

Lithotripsy, extracorporeal shock wave	750.00
Renal endoscopy through nephrotomy or pyelotomy, with removal of foreign body	294.00
Transurethral resection of bladder neck (separate procedure)	200.00

Obstetrical*

Vaginal delivery *	210.00
Cesarean delivery *	290.00

OPTIONAL BENEFIT
HEALTH SCREENING BENEFIT

Health Screening Benefit - We will pay the actual charges up to the Calendar Year Maximum Benefit of $**[100 units]** for each Covered Person, when the Covered Person is given any of the following examinations or tests while this Certificate is in force, which has been recommended by or performed under the supervision of a Physician:

Blood Test for Triglycerides
Bone Marrow Testing
Breast Ultrasound
CA 15-3 (blood test for breast cancer)
CA 125 (blood test for ovarian cancer)
Cardiac Stress Test
CEA (blood test for colon cancer)
Chest X-ray
Colonoscopy
Complete Blood Count
Cystoscopy
Echocardiogram
Electrocardiogram
Electroencephalogram
Endoscopy
Fasting Blood Glucose Test
Flexible Sigmoidoscopy
Hemoccult Stool Analysis
Mammography
Pap Smear
PSA (blood test for prostate cancer)
Serum Cholesterol Test to determine level of HDL and LDL
Serum Protein Electrophoresis (blood test for myeloma)
Thermography

The Calendar Year Maximum benefit for all covered children combined is equal to twice the Calendar Year Maximum for an individual child.

Exclusions and Limitations - Benefits are not payable for examinations or tests for which no charge is normally made in the absence of insurance.

B 20620 CRT-E OPB11 IS ON THE REVERSE OF THIS PAGE.

THIS PAGE LEFT INTENTIONALLY BLANK.

BANKERS FIDELITY LIFE INSURANCE COMPANY®

4370 Peachtree Road, N.E., P. O. Box 105185, Atlanta, GA 30348-5146

BANKERSWORKSITE

Group ID #:

CASE APPROVAL AND EMPLOYER AGREEMENT

PLEASE PRINT

1. COMPANY INFORMATION

Company Name:			Employer Federal Tax ID Number:
Physical Street Address:	**City:**	**State:**	**Zip+4:**
			-
Mailing Address (P.O. Box, etc.):	**City:**	**State:**	**Zip+4:**
			-
Name of Contact (First, Last):	**Title:**		
Telephone Number:	**Extension:**	**Fax Number:**	**Email Address:**

2. BILLING INFORMATION (IF DIFFERENT FROM ABOVE)

Billing Address:	City:	State:	Zip+4:
			-
Name of Billing Contact (First, Last):	**Title:**		
Telephone Number:	**Extension:**	**Fax Number:**	**Email Address:**

If more than one location is to be billed, please attach a complete listing of locations including addresses and contact information.

3. BUSINESS INFORMATION

Type of Business:

Principal Activity:

Is the business seasonal? ..... ❑ Yes ❑ No

If "Yes", will seasonal employees be included? ..... ❑ Yes ❑ No

Are products offered under an ERISA plan? ..... ❑ Yes ❑ No

If so, which ones: ❑ Accident Expense Plan 2 ❑ Cancer Expense ❑ Hospital Indemnity

Total Number of Active Employees: _____

Total Number of Eligible Employees: _____

Eligibility Period: ❑ 30 days ❑ 60 days ❑ 90 days ❑ 120 days ❑ 180 days ❑ Other____

Active employees are those who are working a minimum of 20 hours per week at the worksite for earnings that are paid regularly, and they are performing the material and substantial duties of their regular occupation. The worksite must be: 1) the employer's usual place of business; 2) an alternative worksite at the direction of the employer; or 3) a location to which the named insured's job requires him to travel. Temporary or leased employees are excluded.

Deduction Method:

❑ Weekly
❑ Bi-weekly
❑ Semi-monthly
❑ Monthly
❑ Other _____

Billing Method:

❑ Monthly
❑ 9 months
❑ 10 months
❑ 13 months (28 days)
❑ Other _____

4. CASE INFORMATION

Individual Benefits Offered:

❑ Accident Expense ❑ Mediflex*Plus*® ❑ Dual Disability ❑ Level Term Life ❑ Whole Life
❑ Cancer Expense ❑ Short-Term Care ❑ Disability Income ❑ Level Term Life with Critical Illness Rider ❑ Legacy Income: Which product does this goes with? ❑ Term Life ❑ Whole life

Group Benefits Offered*:	Employer Contribution: (check one)		Percentage of Employer Contribution: (check one)					Applies to: (check one)		Requesting Guarantee Issue?*
	Yes	No	100%	75%	50%	25%	Other %	Employee	Employee & Dependents	
❑ Mediflex*Plus*®							%			❑ Yes ❑ No
❑ Term Life							%			❑ Yes ❑ No
❑ Critical Illness							%			❑ Yes ❑ No

* Guarantee Issue is only available if minimum participation requirements are met.

Initial enrollment date:	Estimated completion date:	Initial deduction date:	Estimated policy effective date:

5. CREDIBLE COVERAGE

A. Is the deductible on the major medical or comprehensive health plan being increased? ..... ❑ Yes ❑ No

If Yes: Current Deductible_____ New Deductible _____ Effective Date _____

B. If the Group Mediflex*Plus*® product is being offered, is it a replacement of similar coverage? ..... ❑ Yes ❑ No

If Yes to either A or B, please provide the previous company name, termination date of the prior plan if applicable and a copy of the previous coverage, in order to determine if credible coverage exists for the purpose of waiving the pre-existing conditions limitation period.

6. THIRD PARTY ADMINISTRATOR INFORMATION

xCalibre: ❑ Yes ❑ No Other: ❑ Yes ❑ No (if "YES" complete below)

Company Name:			Company Federal Tax ID Number:	
Address:	City:		State:	Zip+4:
				-

Name of Contact (First, Last):	Title:	Telephone Number:	Extension:	Fax Number:	Email Address:

7. PAYROLL DEDUCTION AGREEMENT - COMPANY

The Employer understands, acknowledges and certifies the following:

Insurance agents/producers of Bankers Fidelity Life Insurance Company ("Bankers") are authorized to contact the employees of the Company concerning the purchase of Bankers insurance products. In order to facilitate payment of premiums, the Company will honor payroll deduction requests, provided that the Payroll Deduction Authorization is signed by the employee.

If the employee is responsible for any portion of the premium payment, such premiums will be deducted from the wages of the participating employees and will be remitted to Bankers not later than five working days after the final deduction is made. The Company understands that failure to remit premiums promptly, with or without a monthly billing, may result in the termination of insurance for our employees and their dependents in accordance with the terms of their policy(ies). Remittance of insurance premiums by any method shall not constitute payment of insurance premiums until the remittance has been received by Bankers and honored by the financial institution upon which it is drawn when presented.

The Company understands that a change in status of employee such as termination of employment, leave of absence, maternity, voluntarily discontinuance of payroll deduction or any other means that would cause payroll deductions to cease must be reported to Bankers.

It is further agreed that this Agreement may be terminated by either party upon at least 30 days written notice. In the event of termination of this Agreement, the payment of premiums will be a matter of accounting between the participating employees and Bankers.

IMPORTANT NOTICE, PLEASE READ NOTE: The Mediflex*Plus*® hospital indemnity, if offered, is not intended to replace comprehensive or major medical insurance. It is not comprehensive or major medical insurance and provides only scheduled, limited indemnity benefits which are designed to cover a part of the cost that a covered person may incur upon the occurrence of a covered injury or sickness, such as a doctor's office visit or hospitalization. I further agree that we will inform and educate all current and future employees regarding the maximum coverage levels afforded under the policy.

WARNING: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto may be committing a fraudulent insurance act, which is a crime and could subject such person to criminal and civil penalties.

By: _____ Date: _____
Authorized Employer Signature Date Signed

Title: _____

8. PRODUCER INFORMATION

Name of Agent (First, Last):	Agent #:	Telephone Number:	Extension:	Fax Number:	Email Address:

If more than five producers, attach a list with above information.

I hereby certify that: (a) all information set forth above is correct to the best of my knowledge and belief; (b) I have complied fully with the underwriting rules; (c) I have explained the proposed insurance Policy in detail; and (d) to the best of my knowledge and belief the proposed Policyholder is financially sound.

[x] _____ License No. _____ Code _____
Signature of Licensed Agent

PLEASE DO NOT WRITE BELOW THIS LINE

HOME OFFICE REMARKS AND CONFIRMATION

Date Received _____ Date Approval Letter Sent _____

Census Received _____ Initial Enrollment Date _____

Initial Deduction Date _____ Billing Mode: _____

Initial Policy Effective Date _____ Date Received _____

Confirmed Pay Periods per year: ❑ 52 ❑ 26 ❑ 24 ❑ Other (how many) _____

Approved by: _____ Date: _____

BANKERS FIDELITY LIFE INSURANCE COMPANY®

4370 Peachtree Road, N.E., P.O. Box 105146, Atlanta, Georgia 30348-5146 (404) 266-5600

❑ **Enrollment** (*complete entire form*)

❑ **Declination** *(complete only name and signature)*

(PLEASE PRINT)

Agent/Broker Name	Agent Number

PROPOSED INSURED (First Name, Middle Initial, Last Name)	Relationship	Sex	Age	Born Mo.	Born Day	Born Yr.	State of Birth	Social Security Number
1.	Primary Insured							– –
2.	❑ Spouse ❑ Dependent Child							– –
3.	Dependent Child							– –
4.	Dependent Child							– –
5.	Dependent Child							– –

ADDRESS Number and Street or R.F.D.	City	County	State	Zip Code

Phone Number: ( )	E-mail Address:	First Day of Employment	Number of Hours Worked per Week

SELECT THE COVERAGE YOU WANT

❑ Group Hospital Indemnity_____ ❑ Group Level Term_____ ❑ Group Critical Illness_____

I, the undersigned Proposed Insured,

(1) represent that the above information is correct and complete to the best of my knowledge and belief. I acknowledge and fully understand that any significant misstatements or omissions in completing this enrollment form may delay processing my enrollment request and/or result in the denial of benefits or participation under the insurance policy issued by Bankers Fidelity Life Insurance Company®.

(2) understand that I must be actively at work for the required number of hours specified in the group policy and/or my employers participation agreement in order to maintain coverage. I understand that the coverage for which I am applying provides supplemental benefits only and is not meant to replace major medical or comprehensive health insurance coverage.

(3) understand that if I am applying for group health insurance the coverage applied for will not pay benefits for any loss incurred for pre-existing conditions during the first year after the Effective Date. A pre-existing condition is a medical condition for which: 1) medical advice or treatment was recommended by, or received from, a Physician within the one (1) year period before the Effective Date; or 2) symptoms existed within the one (1) year period before the Effective Date which would cause an ordinarily prudent person to seek diagnosis, care or treatment. ***This Pre-existing Condition Limitation will be waived if prior credible coverage requirements have been verified by my employer and approved by Bankers Fidelity Life Insurance Company.***

(4) authorize the required payroll deductions associated with my elective coverage (and the coverage of my dependents, if any). I reserve the right to revoke this deduction at any time with written notification to the insurer and my employer.

WARNING: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto may be committing a fraudulent insurance act, which is a crime and could subject such person to criminal and civil penalties.

Dated at _____ , on _____ X _____

City and State — Month, Day, Year — Proposed Insured's signature

I, the undersigned agent, certify:

(1) I have personally interviewed the Proposed Insured; and

(2) I have accurately recorded the information supplied by the Proposed Insured.

Dated at _____ , on _____ X _____

City and State — Month, Day, Year — Agent's signature

SERFF Tracking #:	*BFLI-128600035*	***State Tracking #:***		***Company Tracking #:***	*AR B 20620 MP-E*

State:	*Arkansas*	***Filing Company:***	*Bankers Fidelity Life Insurance Company*
TOI/Sub-TOI:	*H14G Group Health - Hospital Indemnity/H14G.000 Health - Hospital Indemnity*		
Product Name:	*Group Hospital Indemnity*		
Project Name/Number:	*/*		

Rate Information

Rate data applies to filing.

Filing Method:	SERFF
Rate Change Type:	Neutral
Overall Percentage of Last Rate Revision:	0.000%
Effective Date of Last Rate Revision:	06/29/2012
Filing Method of Last Filing:	n/a

Company Rate Information

Company Name:	Overall % Indicated Change:	Overall % Rate Impact:	Written Premium Change for this Program:	# of Policy Holders Affected for this Program:	Written Premium for this Program:	Maximum % Change (where req'd):	Minimum % Change (where req'd):
Bankers Fidelity Life Insurance Company	0.000%	0.000%	$0	0	$0	0.000%	0.000%

SERFF Tracking #:	*BFLI-128600035*	***State Tracking #:***	***Company Tracking #:*** *AR B 20620 MP-E*

State:	*Arkansas*	***Filing Company:***	*Bankers Fidelity Life Insurance Company*
TOI/Sub-TOI:	*H14G Group Health - Hospital Indemnity/H14G.000 Health - Hospital Indemnity*		
Product Name:	*Group Hospital Indemnity*		
Project Name/Number:	*/*		

Supporting Document Schedules

		Item Status:	**Status Date:**
Satisfied - Item:	Flesch Certification	Approved-Closed	10/15/2012
Comments:			
Attachment(s):			
Consumer Notice B 0034 AR.pdf Guaranty Association Notice B 0076 AR.pdf B 20620 MP-E & CRT-E flesch cert.pdf Certificate of Compliance - B 20620 MP-E.pdf			

		Item Status:	**Status Date:**
Satisfied - Item:	Application	Approved-Closed	10/15/2012
Comments:	The applications are filed under the Form Schedule.		

		Item Status:	**Status Date:**
Satisfied - Item:	Statement of Variability	Approved-Closed	10/15/2012
Comments:			
Attachment(s):			
B 20620 MP-E & CRT-E Statement of Variability.pdf			

BANKERS FIDELITY LIFE INSURANCE COMPANY

Atlanta, Georgia

The following information is being provided to you in accordance with Act 197 of the Arkansas Department of Insurance Regulations:

Bankers Fidelity Life Insurance Company
Policyholder Service Department
4370 Peachtree Road, N.E.
Atlanta, Georgia 30319
Toll-Free: 866-458-7500
Fax: (404) 926-4033
bflphs@atlam.com

If we at Bankers Fidelity Life Insurance Company fail to provide you with reasonable and adequate service, you should feel free to contact:

Arkansas Department of Insurance
Consumer Service Division
1200 West Third Street
Little Rock, Arkansas 72201-1904
(510) 371-2640, (800) 852-5494
Fax: (501) 371-2749
insurance.consumers@arkansas.gov

Your Agent:
{Fld0240}
{Fld0241} {Fld0242}
{Fld0243} {Fld0244}
{Fld0245}

This notice is for information only and does not become a part or condition of your policy.

LIMITATIONS AND EXCLUSIONS UNDER THE ARKANSAS LIFE AND HEALTH INSURANCE GUARANTY ASSOCIATION ACT

Residents of this state who purchase life insurance, annuities or health and accident insurance should know that the insurance companies licensed in this state to write these types of insurance are member of the Arkansas Life and Health Insurance Guaranty Association ("Guaranty Association"). The purpose of the Guaranty Association is to assure that policy and contract owners will be protected, within certain limits, in the unlikely event that a member insurer becomes financially unable to meet its obligations. If this should happen, the Guaranty Association will assess its other member insurance companies for the money to pay the claims of policy owners who live in this state and, in some cases, to keep coverage in force. The valuable extra protection provided by the member insurers through the Guaranty Association is not unlimited, however. And, as noted in the box below, this protection is not a substitute for consumers' care in selecting the insurance companies that are well managed and financially stable.

DISCLAIMER

The Arkansas Life and Health Insurance Guaranty Association ("Guaranty Association") may not provide coverage for this policy. If coverage is provided, it may be subject to substantial limitations or exclusions and require continued residency in this state. You should not rely on coverage by the Guaranty Association in purchasing an insurance policy or contract.

Coverage is NOT provided for your policy or contract or any portion of it that is not guaranteed by the insurer or for which you have assumed the risk, such as non-guaranteed amounts held in a separate account under a variable life or variable annuity contract.

Insurance companies or their agents are required by law to provide you with this notice.

The Arkansas Life and Health Insurance Guaranty Association
C/o The Liquidation Division
1023 West Capitol, Suite 2
Little Rock, Arkansas 72202

Arkansas Insurance Department
1200 West Third Street
Little Rock, Arkansas 72201-1904

The state law that provides for this safety-net is called the Arkansas Life and Health Insurance Guaranty Association Act ("Act"). Below is a brief summary of the Act's coverages, exclusions and limits. This summary does not cover all provisions of the Act; nor does it in any way change anyone's rights or obligations under the Act or the rights or obligations of the Guaranty Association.

COVERAGE

Generally, individuals will be protected by the Guaranty Association if they live in this state and hold a life, annuity or health insurance contract or policy, or if they are insured under a group insurance contract issued by a member insurer. The beneficiaries, payees or assignees of policy or contract owners are protected as well, even if they live in another state.

EXCLUSIONS FROM COVERAGE

However, persons owning such policies are NOT protected by the Guaranty Association if:

- They are eligible for protection under the laws of another state (this may occur when the insolvent insurer was incorporated in another state whose guaranty association protects insureds who live outside that state);
- The insurer was not authorized to do business in this state;
- Their policy or contract was issued by a nonprofit hospital or medical service organization, an HMO, a fraternal benefit society, a mandatory state pooling plan, a mutual assessment company or similar plan in which the policy or contract owner is subject to future assessments, or by an insurance exchange.

The Guaranty Association also does NOT provide coverage for:

- Any policy or contract or portion thereof which is not guaranteed by the insurer or for which the owner has assumed the risk, such as non-guaranteed amounts held in a separate account under a variable life or variable annuity contract;
- Any policy of reinsurance (unless an assumption certificate was issued);
- Interest rate yields that exceed an average rate;
- Dividends and voting rights and experience rating credits;
- Credits given in connection with the administration of a policy by a group contract holder;
- Employers' plans to the extent they are self-funded (that is, not insured by an insurance company, even if an insurance company administers them);
- Unallocated annuity contracts (which give rights to group contract holders, not individuals);
- Unallocated annuity contracts issued to/in connection with benefit plans protected under Federal Pension Benefit Corporation ("FPBC") (whether the FPBC is yet liable or not):
- Portions of a policy or contract to the extent assessments required by law for the Guaranty Association are preempted by State or Federal law;
- Obligations that do not arise under the policy or contract, including claims based on marketing materials or side letters, riders, or other documents which do not meet filing requirements, or claims for policy misrepresentations, or extra-contractual or penalty claims;
- Contractual agreements establishing the member insurer's obligations to provide book value accounting guarantees for defined contribution benefit plan participants (by reference to a portfolio of assets owned by a nonaffiliated benefit plan or its trustees).

LIMITS ON AMOUNT OF COVERAGE

The Act also limits the amount the Guaranty Association is obligated to cover: The Guaranty Association cannot pay more than what the insurance company would owe under a policy or contract. Also, for any one insured life, the Guaranty Association will pay a maximum of $300,000 – no matter how many policies and contracts there were with the same company, even if they provided different type of coverages. Within this overall $300,000 limit, the Association will not pay more than $300,000 in health insurance benefits, $300,000 in present value of annuity benefits, or $300,000 in life insurance death benefits or net cash surrender values – again, no matter how many policies and contracts there were with the same company, and no matter how many different types of coverages. There is a $1,000,000 limit with respect to any contract holder for unallocated annuity benefits, irrespective of the number of contracts held by the contract holder. These are limitations for which the Guaranty Association is obligated before taking into account either its subrogation and assignment rights or the extent to which those benefits could be provided out of the assets of the impaired or insolvent insurer.

BANKERS FIDELITY LIFE INSURANCE COMPANY

4370 Peachtree Road, N.E., Atlanta, Georgia 30319
(404) 266-5683

FLESCH SCORE CERTIFICATION

B 20620 MP-E – Group Master Policy

Words:	1,782
Sentences:	81
Score:	***46.3***

B 0214 EDF2012 – Enrollment Form

Words:	217
Sentences:	14
Score:	***45.6***

B 20620 CRT-E – Certificate of Insurance

Words:	3,582
Sentences:	143
Score:	***52.1***

B 0214 CA – Employer Agreement

Words:	311
Sentences:	26
Score:	***46.3***

I hereby certify that the Flesch reading ease score of the above forms is as shown.

Sharon A. White
Vice President; Legal/Compliance

June 19, 2012
Date

CERTIFICATE OF COMPLIANCE

ARKANSAS

The Bankers Fidelity Life Insurance Company certifies that the form filing for:

B 20620 MP-E – Limited Benefit Hospital Confinement Indemnity Coverage Policy

meets the provisions of the Rule 19, as well as all other requirements of the Arkansas Department of Insurance.

Gene Cloate
President

September 10, 2012
Date

STATEMENT OF VARIABILITY

Limited Benefit Hospital Confinement Indemnity Coverage

B 20620 MP-E – Group Policy

Item	Variable Description:
Group Policyholder	Name of Employer
Group Policy Effective Date	Date Group Policy is issued to Employer
Group Policy Number	Unique identifying number assigned to Employer Group
State of Delivery	State in which the group application is signed and the policy issued
Premiums due on:	premium due date based on effective date and billing mode
First Renewal Date	One year from Effective Date
Minimum Participation Requirements	based on size of group

B 20620 CRT-E – Certificate of Insurnace

Item	Variable Description:
Group Policyholder	Name of Employer to whom Group Policy was issued
Certificate Number	Unique identifying number assigned to each Certificate issued
Group Policy Number	Unique identifying number assigned to Employer Group
Certificate Date	date on which Certificate is effective for individual Insured Member
Insured Person(s)	names of each individual covered under certificate
Relationship to Insured	relationship to Insured Member
Issue Age	age at issue of each individual insured person
Sex	sex of each individual insured person
Effective Date	effective date of coverage for each individual insured person
Daily Hospital Confinement Benefit	amount of benefit selected by Insured Member
Calendar Year Maximum	amount based on benefit times max number of days of confinement
Optional Benefits	titles of optional benefits selected by Insured Member
Additional Daily Hospital Confinement Benefit	benefit amount selected by Insured Member
First Day Confinement Benefit	benefit amount selected by Insured Member
Physician’s Office Visit Benefit	benefit amount selected by Insured Member
Surgical Benefit Amount	benefit amount selected by Insured Member
Health Screening Benefit	benefit amount selected by Insured Member
Emergency Accident – Accidental Death Benefit	benefit amount selected by Insured Member
Emergency Accident – Dismemberment Benefit	benefit amount selected by Insured Member
Emergency Accident – Emergency Visit Benefit	benefit amount selected by Insured Member
Emergency Accident – Ambulance Benefit	benefit amount selected by Insured Member